

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Summerlin		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 N Tenaya Way Las Vegas, NV 89128	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) a peripheral intravenous (IV) access was not inserted without a physician order 2) and complications to the IV access which resulted in incomplete administration of an IV medication was communicated to the physician and documented in the resident's electronic health record (EHR) for 1 of 13 sampled residents (Resident 61). The deficient practice had the potential to place the resident at risk for other IV-related complications such as pain and unresolved dehydration. Findings include: Resident 61 (R61) was admitted on [DATE], with diagnoses including paralytic syndrome following cerebral infarction and dehydration. On 01/27/2026 in the morning, R61 was lying in bed, alert, with a peripheral IV access on right hand with the dressing dated 01/16/2026. IV tubing was looped around an IV pole where a half empty bag of normal saline (NS) hung by the right side of the resident's bed. R61 explained the IV access was placed yesterday because the resident was not drinking enough but verbalized not knowing why the IV tubing was disconnected and NS bag was half empty. A physician order dated 01/26/2026 (12:02 PM), documented to give Dextrose D5 %- 0.45 percent (%) sodium chloride at 50 cubic centimeters per hour (cc/hr.) times two liters for hydration. The medical record lacked documented evidence a physician order was obtained for the insertion of the peripheral IV access and documentation of the insertion procedure such as site location, needle gauge, number of attempts, patient response and complications which may have resulted in the incomplete administration of the prescribed IV medication. On 01/28/2026 at 12:30 PM, a charge nurse indicated receiving a telephone order from R61's provider to administer two bags of D5-0.45% NS at 55 cc/hr. until completed. The charge nurse indicated receiving the order on 01/26/2026 between 10:00 AM to 11:00 AM. The charge nurse acknowledged an order for IV access insertion was not obtained nor transcribed in the resident's EHR. The charge nurse indicated an IV medication order automatically meant IV access would have been needed. The facility's Medication Order policy (undated), documented telephone orders were promptly entered into the resident's EHR. On 01/28/2026 at 12:35 PM, the Director of Nursing (DON), who was present during the interview with the charge nurse, interrupted stating a separate order was required for an IV access insertion. The DON indicated telephone orders were written on a physician order form or entered directly into the resident's EHR prior to the insertion procedure. The DON acknowledged personally entering the physician orders for the peripheral IV access insertion and care into R61's EHR after noticing the IV line on R61's right hand during morning rounds on 01/27/2026 at 7:20 AM. The medical record lacked a documented reason to explain why R61's IV medication was interrupted, and evidence a physician was notified of complications to R61's IV access. On 01/28/2026 at 12:52 PM, the charge nurse and DON confirmed there was no documentation explaining why R61's IV fluid administration was interrupted, and whether the physician was notified. On 01/28/2026 at 12:57 PM, a registered nurse (RN) recounted (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 295092	Facility ID: 295092 If continuation sheet Page 1 of 3

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inserting R61's peripheral IV access on 01/26/2026 at approximately 5:00 PM and initiated IV fluid administration related to the resident's dehydration status. The RN indicated being aware a physician order was required prior to the insertion but assumed the order had already been entered by the charge nurse who had instructed the RN to insert the IV access and initiated IV fluids to R61. On 01/28/2026 at 1:00PM, the RN indicated starting the shift at 6:00 AM and receiving report from night shift that R61's IV access was patent with no issues. The RN noticed R61's IV access started leaking mid-morning which resulted in discontinuing the IV medication and disconnecting the tubing. The RN acknowledged documentation of the IV access complication and interruption of treatment should have been reported to the provider immediately and documented in the resident's EHR but became busy with other patient care. The facility's Patient Care policy (undated) documented entries to the medical record were made at the time the action occurs. On 01/28/2026 in the afternoon, the DON indicated only one-half of the first NS bag had been administered to R61 since receiving the physician order on 01/26/2026 in the morning and there was no documentation explaining the IV complication which resulted in incomplete administration of R61's fluids along with no evidence of physician notification. The facility's IV Access Device policy (undated) documented the facility ensured IV accesses were managed safely to protect residents from complications and improper device management, allowing continuity of treatment. A physician order was required for device insertion, assessment was documented and the provider was notified immediately when complications were detected.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders for pain medications were followed for 1 of 13 sampled residents (Resident 9). The deficient practice had the potential to place the residents at risk for inadequate pain control. Findings include: Resident 9 (R9) was admitted on [DATE], with diagnoses including hemicolectomy (surgical removal of part of the colon) and malignant neoplasm of the colon. On 01/27/2026 in the morning, R9 pulled up their gown revealing a surgical scar in the abdominal area. R9 indicated severe unrelenting pain caused them to present to the hospital where the resident was diagnosed with colon cancer which had spread. A hospital Discharge summary dated [DATE], documented R9 presented with abdominal pain which worsened over the past week. A mass was identified in the middle ascending colon which was confirmed as colon cancer with metastasis to the liver and nodules throughout the peritoneum. A physician order dated 12/31/2025, documented to give Acetaminophen 650 milligrams (mg) for moderate pain level four to six out of 10 (4-6/10) in the pain scale. A physician order dated 12/31/2025, documented to give Oxycodone 5 mg for severe pain seven to 10 (7-10/10) in the pain scale. The medication administration record (MAR) for January 2026, revealed R9 was given Acetaminophen when the resident expressed severe pain on: 01/14/2026 at 6:38 PM at pain level 7/10-01/15/2026 at 2:06 PM at pain level 7/10-01/16/2026 at 4:36 PM at pain level 8/10-01/16/2026 at 8:22 PM at pain level 7/10-01/18/2026 at 6:03 PM at pain level 7/10-01/20/2026 at 10:41 AM at pain level 7/10-01/21/2026 at 5:57 PM at pain level 7/10-01/22/2026 at 2:24 PM at pain level 10/10 On 01/28/2026 at 11:51 AM, a registered nurse (RN) assigned to R9 indicated being familiar with the resident's pain issues which were related to cancer. The RN explained R9 had two pain medication orders: Acetaminophen for moderate pain and Oxycodone for severe pain. The RN explained when R9 complained of pain, the resident's pain was assessed for location, description and intensity using the pain scale and the appropriate medication was administered. After reviewing R9's MAR, the RN confirmed Acetaminophen was administered when the resident complained of severe pain rated at 7 to 10 on the pain scale. The RN indicated not giving the appropriate pain medication placed the resident at risk for inadequate pain control. On 01/28/2026 at 12:03 PM, the Director of Nursing (DON) indicated being familiar with R9 who was admitted to the facility following a diagnosis of colon cancer with metastasis which was the reason pain management was a top priority for this resident. The DON indicated there were two pain medications ordered for R9, Acetaminophen for moderate pain (4-6/10) and Oxycodone (7-10/10). The DON reviewed R9's MAR and confirmed physician orders were not followed when Acetaminophen was administered for severe pain on: 01/14/2026, 01/15/2026, 01/16/2026, 01/16/2026, 01/18/2026, 01/20/2026, 01/21/2026, and 01/22/2026. The DON indicated this placed R9 at risk for inadequate pain control. The facility's Pain Management policy (undated) documented that all residents were assessed for pain upon admission and educated regarding pain management and current orders. Residents were assessed for intensity of pain utilizing a standard pain scale of zero to 10. Pain medications were administered according to the pain assessment, location and intensity.		